SECTION 7

Ambulatory care

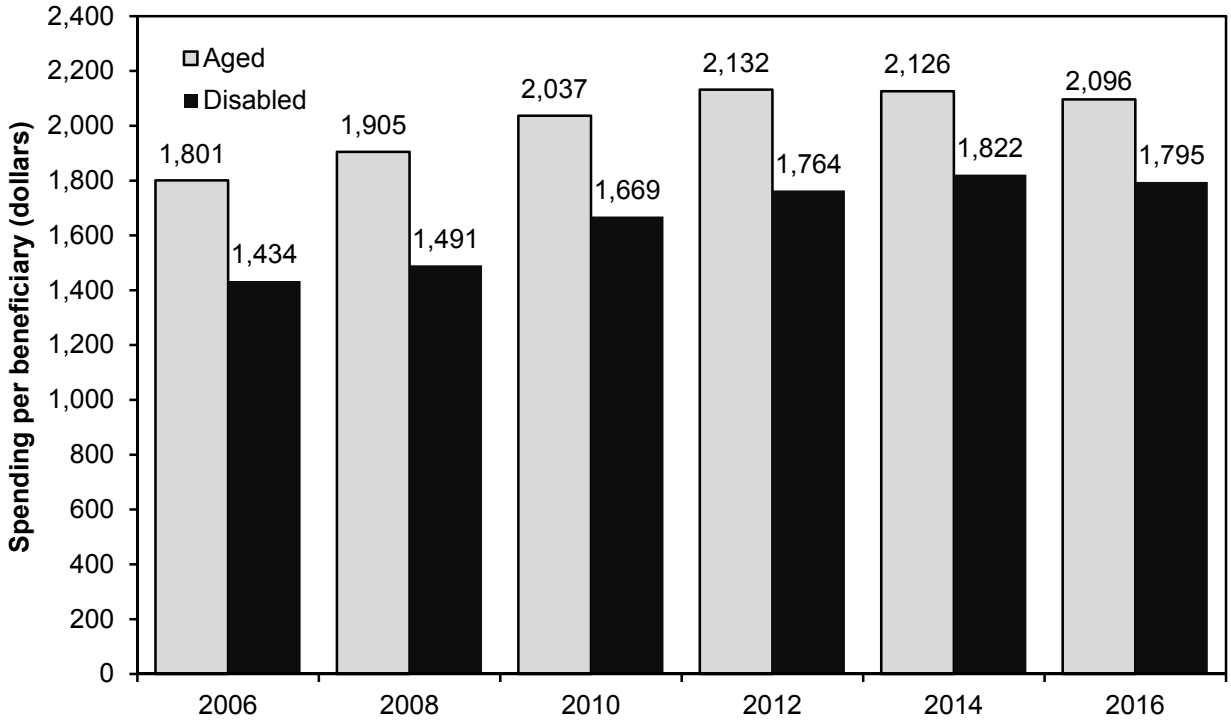
Physicians and other health professionals

Hospital outpatient services

Ambulatory surgical centers

Imaging services

Chart 7-1. Medicare spending per fee-for-service beneficiary on services in the fee schedule for physicians and other health professionals, 2006–2016



Note: Dollar amounts are Medicare spending only and do not include beneficiary cost sharing. The category "disabled" excludes beneficiaries who qualify for Medicare because they have end-stage renal disease. All beneficiaries ages 65 and over are included in the "aged" category.

Source: The annual report of the Boards of Trustees of the Medicare trust funds 2017.

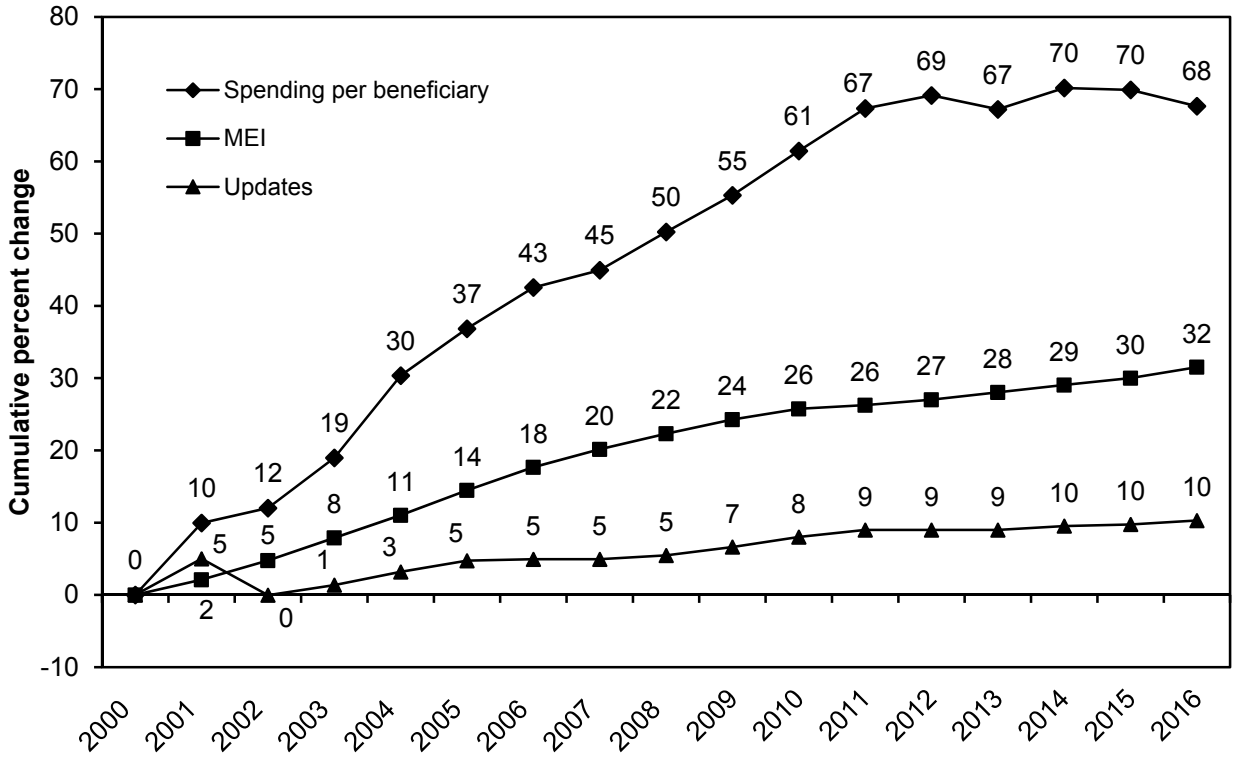
- The fee schedule for physicians and other health professionals includes a broad range of services such as office visits, surgical procedures, and diagnostic and therapeutic services. "Other health professionals" refers to nurse practitioners, physician assistants, physical therapists, and other clinicians. Total fee schedule spending was $69.9 billion in 2016.

- Spending per fee-for-service beneficiary for fee schedule services for aged beneficiaries (ages 65 and over) increased between 2006 and 2012. Spending for disabled beneficiaries (under age 65) increased between 2006 and 2014. From 2006 to 2016, spending per beneficiary for all beneficiaries grew at a cumulative rate of 18 percent.

- The small decline in spending per beneficiary in 2016 was caused by several factors, including the net effects of the small increase in volume (1.6 percent), a larger penalty for clinicians who did not submit data under the Physician Quality Reporting System, and a larger penalty for clinicians who did not meet the electronic health record meaningful use requirement.

- Per capita spending for disabled beneficiaries is lower than per capita spending for aged beneficiaries. In 2016, for example, per capita spending for disabled beneficiaries was $1,795 compared with $2,096 for aged beneficiaries. However, spending per capita grew faster for disabled beneficiaries than aged beneficiaries between 2006 and 2016.

Chart 7-2. Growth in the volume of clinician services caused fee schedule spending to increase faster than input prices and payment updates, 2000–2016

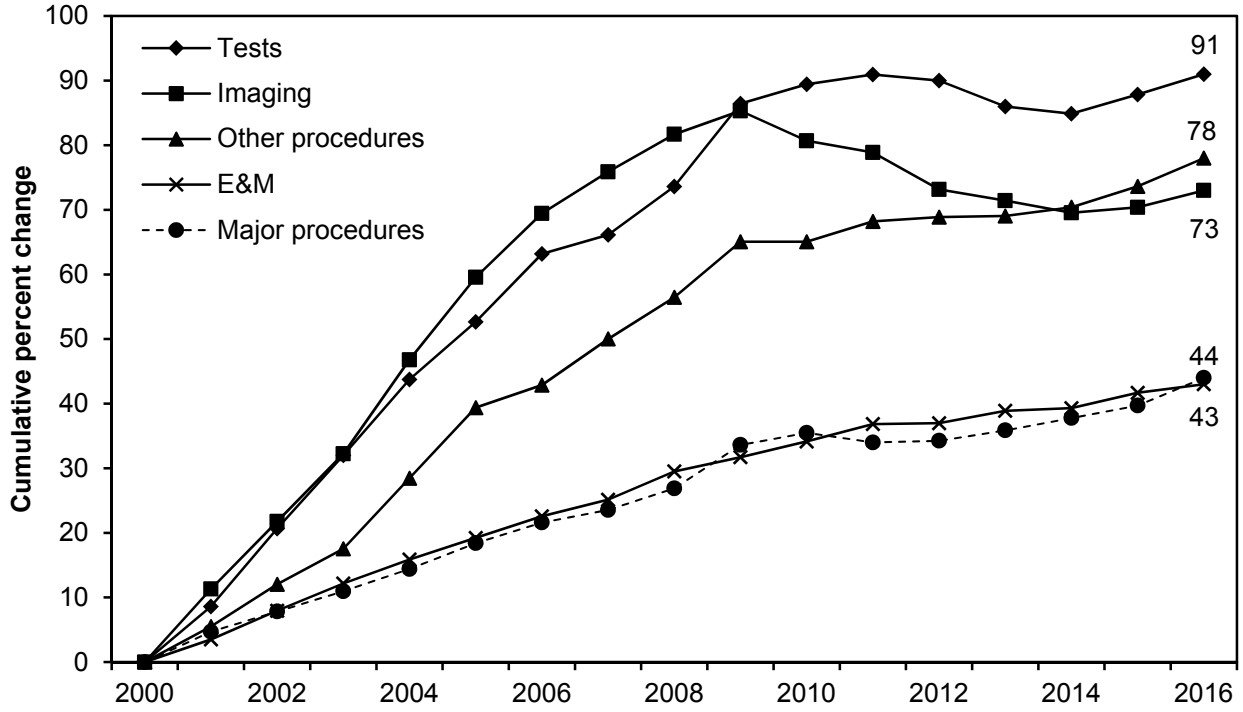


Note: MEI (Medicare Economic Index). The MEI measures the change in clinician input prices. "Spending per beneficiary" includes only services paid under the fee schedule for physicians and other health professionals and excludes services paid under the clinical laboratory fee schedule.

Source: The annual report of the Boards of Trustees of the Medicare trust funds 2017. Clemens, K., Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2014. Estimated sustainable growth rate and conversion factor, for Medicare payments to physicians in 2015. Fact sheet. https://www.cms.gov/medicare/medicare-fee-for-service-payment/sustainablegratesconfact/downloads/sgr2015p.pdf. Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2017. Market basket data. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.html.

- From 2000 to 2016, Medicare spending per fee-for-service beneficiary for services paid under the fee schedule for physicians and other health professionals increased by a cumulative 68 percent.
- Spending per beneficiary grew much more rapidly over the period than both the fee schedule payment rate updates and the MEI, which measures changes in input prices. Payment updates grew cumulatively by 10 percent, and the MEI increased 32 percent.
- Growth in the volume of services contributed much more to the increase in Medicare spending than payment rate updates. Both factors—volume growth and updates—combined to increase Medicare revenue for physicians and other health professionals.

Chart 7-3. Growth in the volume of clinician services per fee-for-service beneficiary, 2000–2016



Note: E&M (evaluation and management). "Volume" refers to the units of service multiplied by relative value units from the fee schedule for physicians and other health professionals. Volume for all years is measured on a common scale, using relative value units for 2016. Volume growth for E&M from 2009 to 2010 is not directly observable because of a change in payment policy for consultations. To compute cumulative volume growth for E&M through 2016, we used a growth rate for 2009 to 2010 of 1.85 percent, which is the average of the 2008 to 2009 growth rate of 1.7 percent and the 2010 to 2011 growth rate of 2.0 percent.

Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries.

- From 2000 to 2016, the volume of some services furnished by physicians and other health professionals grew much faster than others.
- The volume of tests grew by 91 percent, the volume of "other procedures" (i.e., other than major procedures) grew by 78 percent, and the volume of imaging grew by 73 percent. The comparable growth rates for major procedures and evaluation and management services were only 44 percent and 43 percent, respectively.
- Volume growth increases Medicare spending, limiting funds available for other priorities in the federal budget and requiring taxpayers and beneficiaries to contribute more to the Medicare program. Rapid volume growth may be a sign that some services in the fee schedule for physicians and other health professionals are mispriced.

Chart 7-4. Medicare beneficiaries' ability to get timely appointments with physicians was comparable with privately insured individuals, 2014–2017

	Medicare (ages 65 and older)				Private insurance (ages 50–64)			
Survey question	2014	2015	2016	2017	2014	2015	2016	2017
Unwanted delay in getting an appointment: Among those who needed an appointment, "How often did you have to wait longer than you wanted to get a doctor's appointment?"								
For routine care								
Never	72%[a]	72%[a]	68%[b]	73%[a]	69%[a]	69%[a]	67%	69%[a]
Sometimes	20[ab]	19[a]	22[b]	20	23[a]	23[a]	23	22
Usually	3	4	4	3	4	4	5	4
Always	3	3	3	3	3	3	4	3
For illness or injury								
Never	83[ab]	82[a]	79[a]	80[a]	79[a]	77[a]	75[a]	76[a]
Sometimes	12[ab]	13[ab]	16[a]	15	16[a]	17[a]	19[a]	18
Usually	2	3[b]	2[a]	2	2	3	3[a]	2
Always	1[a]	2	2[a]	1	2[a]	2	3[a]	2

Note: Numbers may not sum to 100 percent due to rounding. Missing responses ("Don't Know" or "Refused") are not presented. Overall sample sizes for each group (Medicare and privately insured) were 4,000 in all years. Sample sizes for individual questions varied.
[a] Statistically significant difference (at a 95 percent confidence level) between the Medicare and privately insured samples in the given year.
[b] Statistically significant difference (at a 95 percent confidence level) from 2017 within the same insurance coverage category.

Source: MedPAC-sponsored annual telephone surveys conducted 2014–2017.

- Most Medicare beneficiaries have one or more doctor appointments in a given year. Their ability to schedule timely appointments is one indicator of access that we examine.
- Medicare beneficiaries (ages 65 and older) report similar (or better) access to physicians for appointments as compared with privately insured individuals ages 50 to 64. For example, in 2017, 73 percent of Medicare beneficiaries compared with 69 percent of privately insured individuals reported "never" having to wait longer than they wanted to get an appointment for routine care.
- Medicare beneficiaries reported slightly more timely appointments for injury and illness as compared with their privately insured counterparts.
- Appointment scheduling for illness and injury is better than for routine care appointments for both Medicare beneficiaries and privately insured individuals.

Chart 7-5. Medicare and privately insured patients who were looking for a new physician reported more difficulty finding one in primary care, 2014–2017

	Medicare (ages 65 and older)				Private insurance (ages 50–64)			
Survey question	2014	2015	2016	2017	2014	2015	2016	2017
Looking for a new physician: "In the past 12 months, have you tried to get a new …?" (Percent answering "Yes")								
Primary care physician	8%	7%[a]	8%[a]	9%[a]	8%	9%[ab]	10%[a]	11%[a]
Specialist	17	16	18	17%[a]	17b	18[b]	18	20[a]
Getting a new physician: Among those who tried to get an appointment with a new physician, "How much of a problem was it finding a primary care doctor/specialist who would treat you? Was it …"								
Primary care physician								
No problem	67	67	64	69[a]	63	63	63	59[a]
Small problem	16	18	15	13	16	18	16	18
Big problem	15	14	20	14[a]	19	17	20	22[a]
Specialist								
No problem	85	87[a]	82	83	85[b]	82[a]	79	81
Small problem	7[b]	7[b]	10	11	9	8	9	11
Big problem	7	6	8[a]	5[a]	6	9	11[a]	8[a]

Note: Numbers may not sum to 100 percent due to rounding. Missing responses ("Don't Know" or "Refused") are not presented. Overall sample sizes for each group (Medicare and privately insured) were 4,000 in all years. Sample sizes for individual questions varied.
[a] Statistically significant difference (at a 95 percent confidence level) between the Medicare and privately insured samples in the given year.
[b] Statistically significant difference (at a 95 percent confidence level) from 2017 within the same insurance coverage category.

Source: MedPAC-sponsored annual telephone surveys, conducted 2014–2017.

- In 2017, only 9 percent of Medicare beneficiaries and 11 percent of privately insured individuals reported looking for a new primary care physician. This finding suggests that most people were either satisfied with their current physician or did not need to look for one.
- Of the 9 percent of Medicare beneficiaries who looked for a new primary care physician in 2017, 27 percent reported problems finding one: 14 percent reported their problem as "big," and 13 percent reported their problem as "small." Although this finding means that only 2 percent of the total Medicare population reported problems finding a primary care physician, the Commission is concerned about the continuing pattern of greater problems accessing primary care than specialty care.
- Of the 11 percent of privately insured individuals who looked for a new primary care physician in 2017, 40 percent reported problems finding one: 22 percent reported their problem as "big," and 18 percent reported their problem as "small."
- In 2017, Medicare beneficiaries and privately insured individuals were more likely to report problems accessing a new primary care physician than a new specialist.

Chart 7-6. Medicare beneficiaries' access to physician care was comparable with privately insured individuals, and minorities in both groups reported unwanted delays more frequently, 2017

	Medicare (ages 65 and older)			Private insurance (ages 50–64)		
Survey question	All	White	Minority	All	White	Minority
Unwanted delay in getting an appointment: Among those who needed an appointment, "How often did you have to wait longer than you wanted to get a doctor's appointment?"						
For routine care						
Never	73%[a]	74%[ab]	69%[b]	69%[a]	70%[a]	66%
Sometimes	20[a]	20	19	22[a]	23	23
Usually	3	3[b]	5[b]	4	4	5
Always	3	2[ab]	6[b]	3	3[ab]	4[b]
For illness or injury						
Never	80[a]	81	78[a]	76[a]	77[b]	72[ab]
Sometimes	15[a]	15[a]	15[a]	18[a]	18[ab]	22[ab]
Usually	2	2	3	2	2	3
Always	1[a]	1[a]	2	2[a]	2[a]	2

Note: Numbers may not sum to 100 percent due to rounding. Missing responses ("Don't Know" or "Refused") are not presented. Overall sample size for each group (Medicare and privately insured) was 4,000 in 2017. Sample size for individual questions varied.
[a] Statistically significant difference (at a 95 percent confidence level) between the Medicare and privately insured populations in the given category.
[b] Statistically significant difference (at a 95 percent confidence level) by race within the same insurance category.

Source: MedPAC-sponsored telephone surveys conducted in 2017.

- In 2017, Medicare beneficiaries (ages 65 and older) reported better access to physicians for appointments in comparison with privately insured individuals ages 50 to 64.
- Access varied by race, with minorities more likely than Whites to report access problems in both insurance categories. For example, in 2017, 81 percent of White Medicare beneficiaries reported "never" having to wait longer than they wanted to get an appointment for an illness or injury compared with 78 percent of minority beneficiaries.

Chart 7-7. Minorities in Medicare were more likely to report problems finding a new specialist than White beneficiaries, 2017

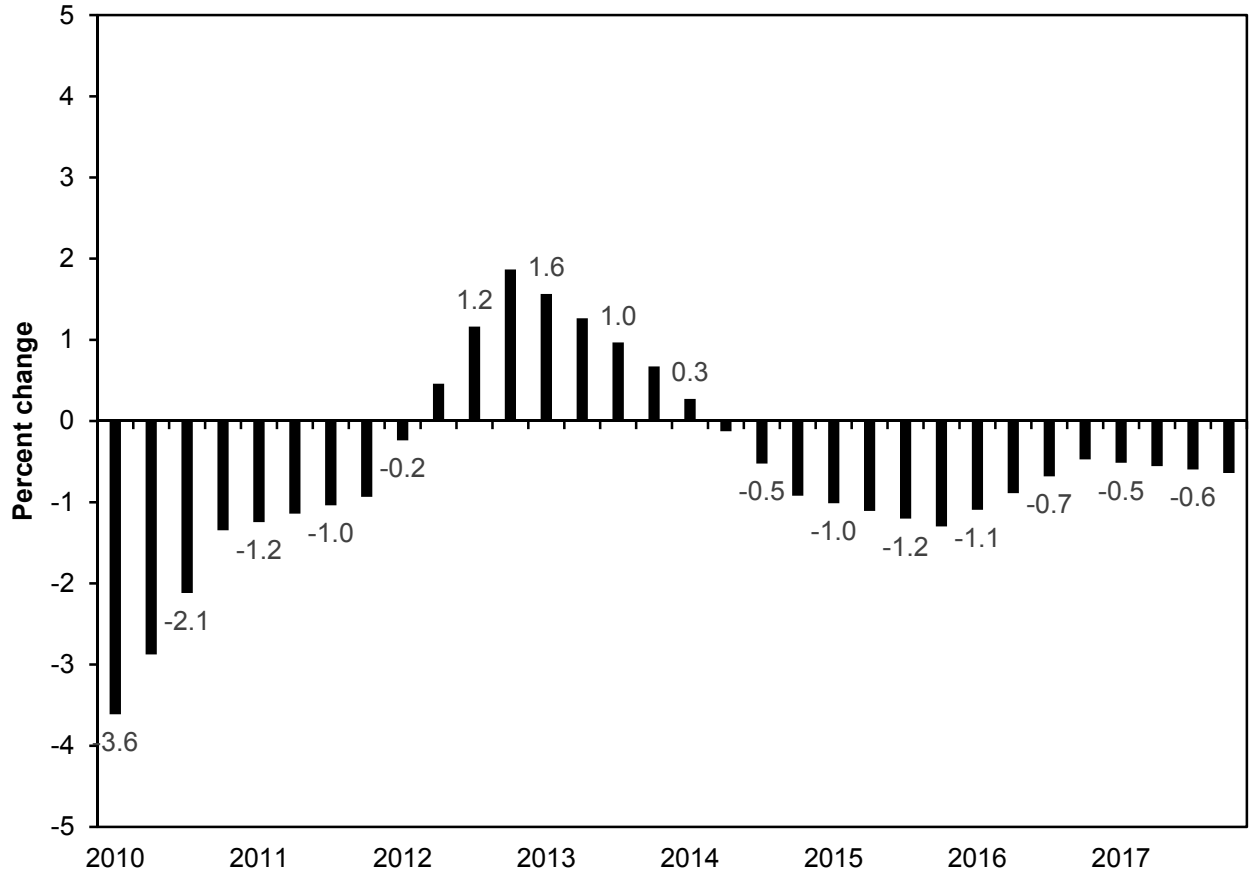
	Medicare (ages 65 and older)			Private insurance (ages 50–64)		
Survey question	All	White	Minority	All	White	Minority
Looking for a new physician: "In the past 12 months, have you tried to get a new …?"						
Primary care physician	9%[a]	8%	9%	11%[a]	11%	10%
Specialist	17	18[a]	15	20	21[ab]	17[b]
Getting a new physician: Among those who tried to get an appointment with a new physician, "How much of a problem was it finding a primary care doctor/specialist who would treat you? Was it …"						
Primary care physician						
No problem	69[a]	67	80[a]	59[a]	58	61[a]
Small problem	13	14	11	18	20	14
Big problem	14[a]	16	8[a]	22[a]	22	21[a]
Specialist						
No problem	83	85[b]	75[b]	81	82[b]	74[b]
Small problem	11	11	13	11	11	13
Big problem	5[a]	3[ab]	11[b]	8[a]	7[ab]	13[b]

Note: Numbers may not sum to 100 percent due to rounding. Missing responses ("Don't Know" or "Refused") are not presented. Overall sample size for each group (Medicare and privately insured) was 4,000 in 2017. Sample size for individual questions varied.
[a] Statistically significant difference (at a 95 percent confidence level) between the Medicare and privately insured populations in the given category.
[b] Statistically significant difference (at a 95 percent confidence level) by race within the same insurance category.

Source: MedPAC-sponsored telephone surveys conducted in 2017.

- Among the small share of Medicare beneficiaries looking for a specialist, minorities were more likely than Whites to report problems finding one.

Chart 7-8. Changes in physicians' professional liability insurance premiums, 2010–2017

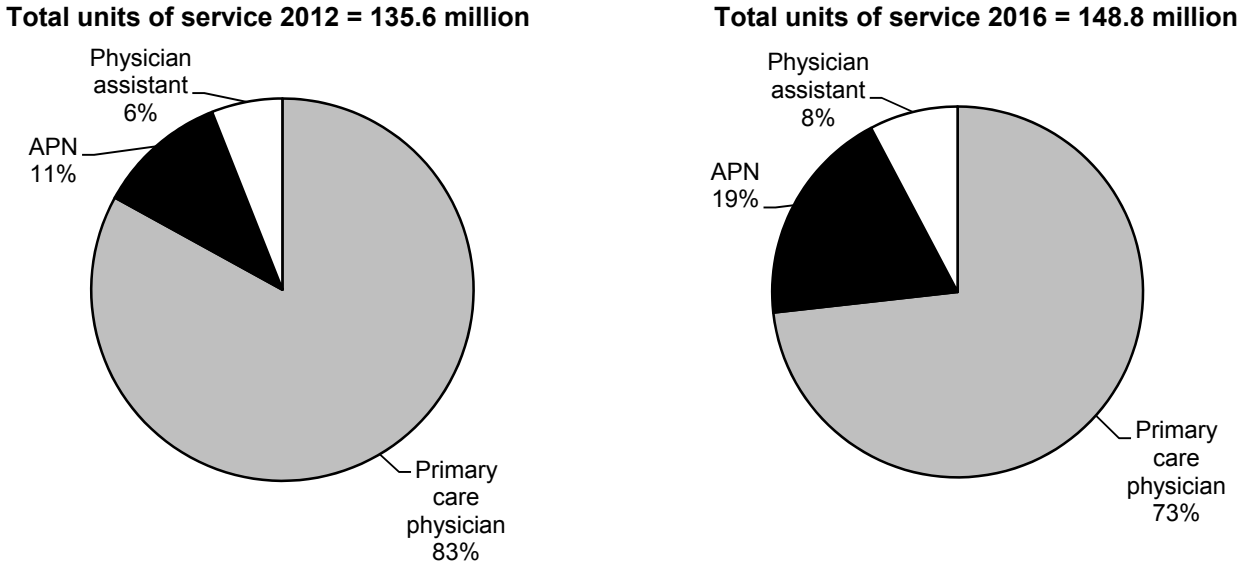


Note: Bars represent a four-quarter moving average percentage change.

Source: CMS, Office of the Actuary. Data are from CMS's Professional Liability Physician Premium Survey.

- Professional liability insurance (PLI) accounts for 4.3 percent of total payments under the fee schedule for physicians and other health professionals.
- Changes in PLI premiums reflect a cyclical pattern, alternating between periods of low premiums (characterized by high investment returns for insurers and vigorous competition) and high premiums (characterized by declining investment returns and market exit).
- Premiums increased from 2002 through 2006 (data not shown) and then declined from the second quarter of 2007 through the first quarter of 2012. Premiums grew slowly from the second quarter of 2012 through the first quarter of 2014, after which point they have declined each subsequent quarter.

Chart 7-9. The shares of primary care services billed by APNs and physician assistants grew, 2012 and 2016



Note: APN (advanced practice nurse). Units of service are specified primary care services—office visits, home visits, visits to patients in extended care facilities, transitional care management, chronic care management, annual wellness visits, and "welcome to Medicare" visits—billed by APNs, physician assistants, or physicians with a specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine. APNs are nurse practitioners and clinical nurse specialists.

Source: MedPAC analysis of claims data for 100 percent of beneficiaries.

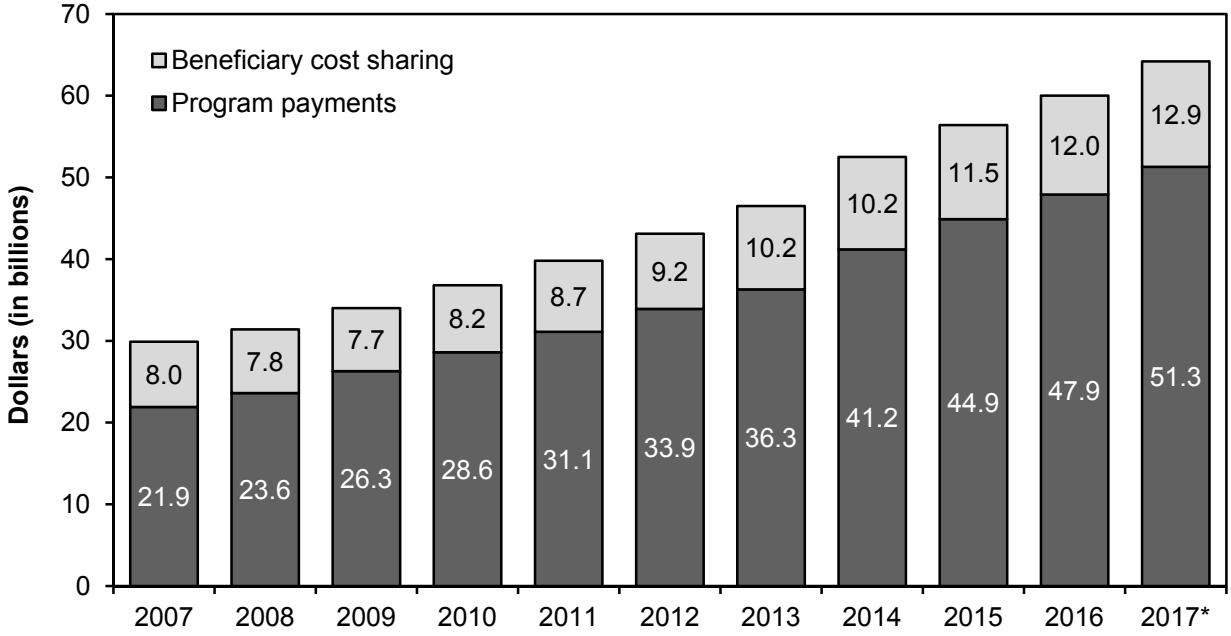
- The distribution of primary care services among the clinicians who bill Medicare for these services—primary care physicians (PCPs), APNs, and physician assistants—has changed over time.

- In 2012, clinicians provided 135.6 million primary care services to beneficiaries. PCPs billed for most of the services (112.8 million, or 83 percent), followed by APNs (15.3 million, or 11 percent), and physician assistants (7.5 million, or 6 percent).

- By 2016, total primary care services had grown to 148.8 million units of service, an increase of about 10 percent compared with 2012. PCPs continued to account for most of these services, but their billed services decreased to 108.1 million, or 73 percent of the total. Primary care services billed by APNs grew to 28.2 million, or 19 percent. Primary care services billed by physician assistants increased to 12.5 million, or 8 percent.

- Units of service billed by primary care physicians include some services provided by APNs and physician assistants but billed as "incident to" or under the direct supervision of physicians. Medicare pays for such services as if physicians had personally furnished them. Claims data do not specify whether a service billed by a physician was provided by an APN or physician assistant.

Chart 7-10. Spending on hospital outpatient services covered under the outpatient PPS, 2007–2017



Note: PPS (prospective payment system). Spending amounts are for services covered by the Medicare outpatient PPS. They do not include services paid on separate fee schedules (e.g., ambulance services and durable medical equipment) or those paid on a cost basis (e.g., corneal tissue acquisition and flu vaccines) or payments for clinical laboratory services. *Estimate.

Source: CMS, Office of the Actuary.

- Overall spending by Medicare and beneficiaries on hospital outpatient services covered under the outpatient PPS from calendar years 2007 to 2017 increased by 115 percent, reaching an estimated $64.2 billion. The Office of the Actuary projects continued growth in total spending, averaging 9.5 percent per year from 2017 to 2019.

- In 2001, the first full year of the outpatient PPS, spending under the PPS was $20.1 billion, including $12.1 billion by the program and $8.0 billion in beneficiary cost sharing (data not shown). The Office of the Actuary estimates that spending under the outpatient PPS was $64.2 billion in 2017 ($51.3 billion in program spending, $12.9 billion in beneficiary copayments). We estimate that the outpatient PPS accounted for about 7 percent of total Medicare program spending in 2017.

- Beneficiary cost sharing under the outpatient PPS includes the Part B deductible and coinsurance for each service. Under the outpatient PPS, beneficiary cost sharing was about 20 percent in 2016.

Chart 7-11. Most hospitals provide outpatient services

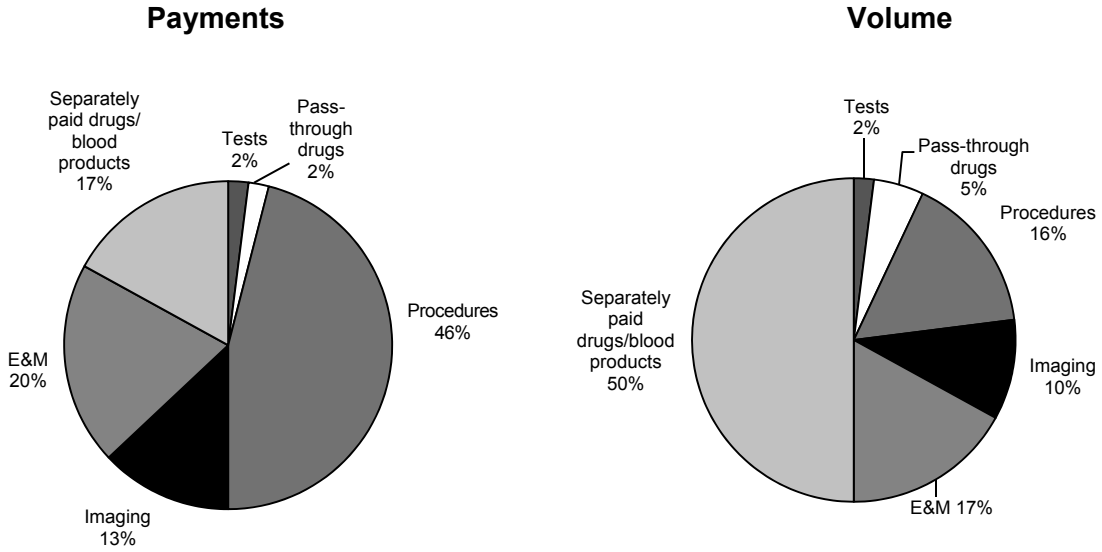
Year	Acute care hospitals	Percent offering		
		Outpatient services	Outpatient surgery	Emergency services
2006	3,651	94%	86%	N/A
2008	3,607	94	87	N/A
2010	3,518	95	90	N/A
2012	3,483	95	91	93%
2014	3,429	96	92	93
2016	3,370	96	93	93
2017	3,346	96	93	92

Note: N/A (not applicable). We list emergency services from 2006 through 2010 as "N/A" because the data source we used in this chart changed the variable for identifying hospitals' provision of emergency services. We believe this change in variable definition makes it appear that the share of hospitals providing emergency services increased sharply from 2010 to 2012, but we question whether such a large increase actually occurred. This chart includes services provided or arranged by acute care short-term hospitals and excludes long-term, Christian Science, psychiatric, rehabilitation, children's, critical access, and alcohol/drug hospitals.

Source: Medicare Provider of Services files from CMS.

- The number of hospitals that furnish services under Medicare's outpatient prospective payment system has declined slowly since 2006, from 3,651 in 2006 to 3,346 in 2017.
- The share of hospitals providing outpatient services remained stable, and the share offering outpatient surgery steadily increased from 2006 through 2014 and has remained stable since then. The share offering emergency services has remained stable over the period we are able to measure accurately.

Chart 7-12. Payments and volume of services under the Medicare hospital outpatient PPS, by type of service, 2016



Note: PPS (prospective payment system), E&M (evaluation and management). "Payments" include both program spending and beneficiary cost sharing but do not include hold-harmless payments. Services are grouped into the following categories, according to the Berenson-Eggers Type of Service codes developed by CMS: evaluation and management, procedures, imaging, and tests. "Pass-through drugs" and "separately paid drugs and blood products" are classified by their payment status indicator.

Source: MedPAC analysis of standard analytic file of outpatient claims for 2016.

- Hospitals provide many types of services in their outpatient departments, including emergency and clinic visits, imaging and other diagnostic services, laboratory tests, and ambulatory surgery.
- The payments for services are distributed differently from volume. For example, in 2016, procedures accounted for 46 percent of payments but only 16 percent of volume.
- Procedures (e.g., endoscopies, surgeries, and skin and musculoskeletal procedures) accounted for the greatest share of payments for services (46 percent) in 2016, followed by evaluation and management services (20 percent), separately paid drugs and blood products (17 percent), and imaging services (13 percent).

Chart 7-13. Hospital outpatient services with the highest Medicare expenditures, 2016

APC title	Share of payments	Volume (thousands)	Payment rate
Total	51%		
All emergency visits	7	13,674	$300
Clinic visits	6	30,842	102
Comprehensive observation services	6	1,474	2,174
Level 2 endovascular procedures	3	203	9,542
Level 2 ICD and similar procedures	3	47	30,490
Diagnostic cardiac catheterization	2	407	2,549
Level 2 lower GI procedures	2	1,400	753
Level 1 intraocular procedures	2	518	1,746
Level 3 electrophysiologic procedures	2	57	15,561
Level 3 radiation therapy	2	1,668	506
Level 3 nuclear medicine and related services	1	731	1,108
Level 3 pacemaker and similar procedures	1	87	9,273
Level 3 musculoskeletal procedures	1	184	4,962
Level 3 ultrasound and related services	1	1,721	417
Level 1 laparoscopy	1	191	4,001
Level 3 endovascular procedures	1	50	14,612
Level 2 ultrasound and related services	1	4,018	154
Level 5 drug administration	1	2,008	280
Level 1 X-ray and related services	1	9,134	61
Level 5 urology and related services	1	159	3,394
Level 1 upper gastrointestinal procedures	1	868	745
Level 2 vascular procedures	1	251	2,247
Level 4 nuclear medicine and related services	1	383	1,284
Level 1 endovascular procedures	1	147	4,592
Level 2 drug administration	1	11,616	42
Level 2 computed tomography with contrast and computed tomography angiography	1	1,346	348
Level 4 drug administration	1	2,614	173
Average APC		535	173

Note: APC (ambulatory payment classification), ICD (implantable cardioverter-defibrillator), GI (gastrointestinal). The payment rate for "all emergency visits" is a weighted average of payment rates from 10 APCs. The shares of payments for the 27 APC categories do not add to the total share of payments (51 percent) because of rounding. The average APC figures in the last line represent averages for all APCs.

Source: MedPAC analysis of 100 percent analytic files of outpatient claims for calendar year 2016.

- Although the outpatient prospective payment system covers thousands of services, expenditures are concentrated in a few categories that have high volume, high payment rates, or both.

Chart 7-14. Effects of SCH transfer payments on hospitals' outpatient revenue, 2014–2016

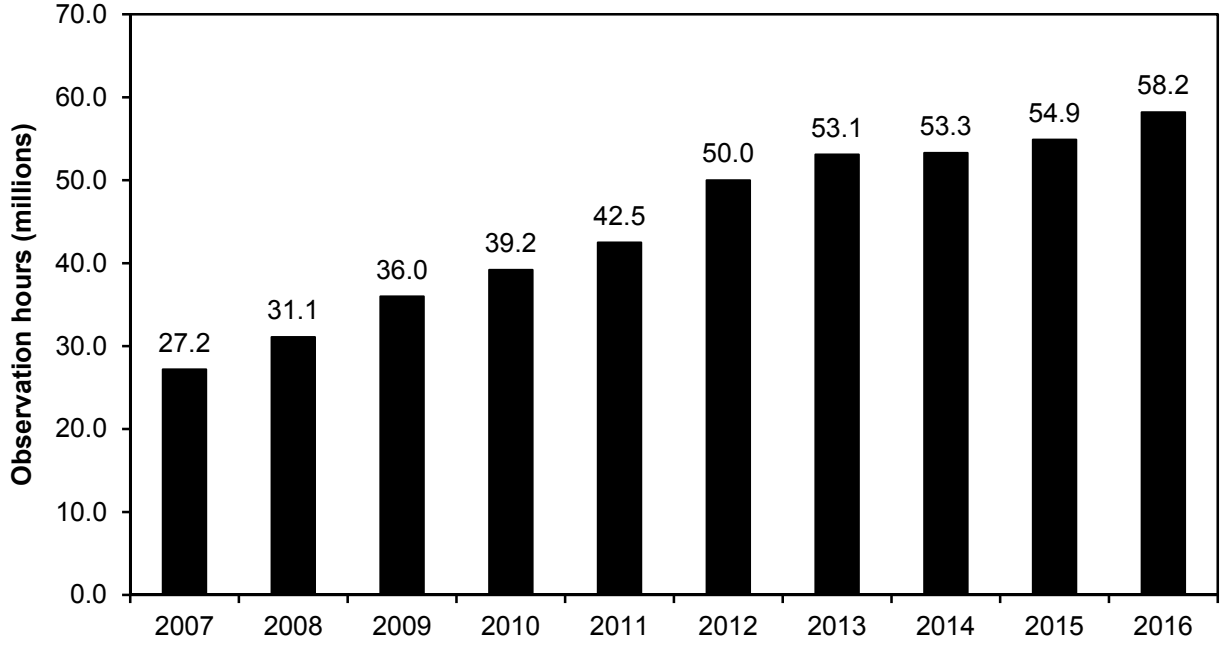
Hospital group	2014 Number of hospitals	2014 Share of payments from SCH transfer	2015 Number of hospitals	2015 Share of payments from SCH transfer	2016 Number of hospitals	2016 Share of payments from SCH transfer
All hospitals	2,953	0.0%	2,915	0.0%	2,870	0.0%
Urban	2,114	–0.4	2,163	–0.4	2,137	–0.4
Rural SCHs	373	5.6	354	5.6	350	5.6
Rural ≤100 beds	347	–0.4	300	–0.4	289	–0.4
Other rural	119	–0.4	98	–0.4	93	–0.4
Major teaching	273	–0.3	286	–0.3	288	–0.3
Other teaching	700	–0.2	695	–0.2	699	–0.2
Nonteaching	1,980	0.3	1,934	0.3	1,882	0.3

Note: SCH (sole community hospital).

Source: MedPAC analysis of Medicare Cost Report files from CMS.

- In 2006, CMS implemented a policy (the "SCH transfer") that increased outpatient prospective payment system (PPS) rates to rural SCHs by 7.1 percent above the standard PPS rates. This policy is made budget neutral by reducing payments to all other hospitals.
- This table reflects the effects of the SCH transfer policy for hospital categories in 2014, 2015, and 2016. We obtained the data for this table from the hospitals' 2014, 2015, and 2016 cost reports.
- The SCH transfer is budget neutral and does not affect total outpatient PPS payments. However, the percentage of total outpatient payments from this policy was 5.6 percent of outpatient revenue for rural SCHs in 2014 through 2016. Also, the SCH transfer policy reduced outpatient payments to small rural hospitals by 0.4 percent each year between 2014 and 2016.

Chart 7-15. Number of hospital outpatient observation hours increased, 2007–2016



Source: MedPAC analysis of Limited Data Set claims for the outpatient prospective payment system 2007–2016.

- Hospitals use observation care to determine whether a patient should be hospitalized for inpatient care, transferred to an alternative treatment setting, or sent home.
- Medicare began providing separate payments to hospitals for some observation services on April 1, 2002. Previously, the observation services were packaged into the payments for the emergency department or clinic visits that occurred with observation care.
- The number of hospital outpatient observation hours (both packaged and separately paid) has increased substantially, from about 27 million in 2007 to more than 58 million in 2016. Before 2007, it was difficult to count the total number of observation hours because hospitals were not required to report packaged observation hours on Medicare claims.

Chart 7-16. Number of Medicare-certified ASCs increased by 8 percent, 2010–2016

	2010	2011	2012	2013	2014	2015	2016
Medicare payments (billions of dollars)	$3.3	$3.4	$3.6	$3.7	$3.8	$4.1	$4.3
New centers (during year)	192	197	174	173	186	158	142
Closed or merged centers (during year)	111	122	112	110	105	91	63
Net total number of centers (end of year)	5,105	5,180	5,242	5,305	5,386	5,453	5,532
Net percent growth in number of centers from previous year	1.5%	1.5%	1.2%	1.2%	1.5%	1.2%	1.4%
Share of all centers that are:							
For profit	95	95	95	95	95	94	94
Nonprofit	3	3	3	3	3	3	3
Government	1	1	1	2	2	3	3
Urban	92	92	93	93	93	93	94
Rural	8	8	7	7	7	7	6

Note: ASC (ambulatory surgical center). Medicare payments include program spending and beneficiary cost sharing for ASC facility services. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Provider of Services file from CMS 2017. Payment data are from CMS, Office of the Actuary.

- ASCs are distinct entities that furnish ambulatory surgical services not requiring an overnight stay. The most common ASC procedures are cataract removal with lens insertion, upper gastrointestinal endoscopy, colonoscopy, and nerve procedures.
- Total Medicare payments per Medicare beneficiary for ASC services increased by approximately 4 percent per year, on average, from 2010 through 2016 (data not shown). Payments per ASC fee-for-service beneficiary grew by 3.3 percent per year during this period. Between 2015 and 2016, total payments rose by 4.9 percent, and payments per beneficiary grew by 3.5 percent (per beneficiary data not shown).
- The number of Medicare-certified ASCs grew at an average annual rate of greater than 1 percent from 2010 through 2016. Each year from 2010 through 2016, an average of 175 new facilities entered the market, while an average of 102 closed or merged with other facilities.
- Compared with earlier years (not shown), the number of ASCs grew slowly from 2010 through 2016. The slower growth may reflect the substantially higher rates that Medicare pays for ambulatory surgical services provided in hospital outpatient departments than in ASCs, the very slow growth of national health care spending and Medicare spending, and the significant increase in hospital employment of physicians.